

REQUEST TO ADD OR DELETE MEMBERS TO A CURRENT FAMILY FEDERAL EMPLOYEES HEALTH BENEFITS ENROLLMENT

To: Insurance Carrier

Please make the following changes to my Federal Employees Health Benefits enrollment.

Copies of documents, as applicable, to support the enrollment change are attached.

- For birth of child, attach copy of proof of birth
- For divorce, attach copy of divorce decree
- For marriage, attach copy of marriage certificate

Name of Employee:	SSN:	ID#:	Name of Health Plan:	Enrollment Code:		
Address:						
ADD THE FOLLOWING FAMILY MEMBERS TO MY COVERAGE						
Name	Zip Code	Date of Birth	Sex	Relationship	Social Security Number	Reason For Addition
DELETE THE FOLLOWING FAMILY MEMBERS FROM MY COVERAGE						
Name	Zip Code	Date of Birth	Sex	Relationship	Social Security Number	Reason For Deletion

Employee Signature

Date